Is Mental Illness Socially Constructed?

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Abstract

This paper will critically analyse, how the use of a bio-medical model, philosophically rooted in positivism and a diagnostic language that confuses "truth" with diagnostic perspectives has led to an obsession with "compliance" on a global scale and a failure to recognize how medical discourses have negatively influenced how peoples' illnesses are experienced, depicted and viewed within society, with specific reference to schizophrenia (Walker, 2006). There have been endeavours by psychologists to homogenize language classification and diagnostic systems across cultures, making the diagnostic criteria universal (Marsella & Yamada, 2010). However, this ethnocentric bias has led to frequent misdiagnosis and ethical harms as it is often taken for granted how certain illnesses are culturally taboo and have particular social and cultural stigmas (Conrad & Barker, 2010; Hassim & Wagner, 2013; Li, Hatzidimitriadou & Psoninos, 2014). This paper concludes that current diagnostic systems are too positivist and clinicians need to aware of the social constructionist element in the diagnosis of mental illness.

Keywords: *Positivism, Social Constructionism, Scientific Method, Discourse, Language*

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The classification and diagnostic model used in the diagnosis of disease is based on Comte's philosophy of positivism (1853), which states that everything can be understood by employing the scientific method (Walker, 2006). This overreliance on the positivist model of diagnosis has led to a mechanist view that human beings can be diagnosed and treated like computers (Conrad & Barker, 2010). The power and reliance on positivism in medical diagnosis has also led to a monopoly on "truth" and rather than being value-neutral, positivism actually reflects and reproduces forms of social inequality (Foucault, 1975,1977). The use of social constructionism offers a caveat to the deterministic principally reductionist approach to the diagnoses of mental illness, employed by the bio- medical model (Conrad & Barker, 2010). Social constructionism is engrained in the theoretical dissimilarity between disease (biological components; Schneider & Conrad, 1981) and illness (social experiences of the condition; Eisenberg, 1977). This essay will critically analyse; how the use of a bio-medical model, philosophically rooted in positivism and a diagnostic language that confuses "truth" with diagnostic perspectives has led to an obsession with "compliance" on a global scale and a failure to recognize how medical discourses have negatively influenced how peoples' illnesses are experienced, depicted and viewed within society, with specific reference to schizophrenia (Walker, 2006; Foucault, 1975, 1977).

The social constructionist view in regards to mental illness centres around learning the distinct way a person creates their world in relation to others (Sampson, 1993; Gergen, 1994; McName & Gergen, 1992). This is in contrast to the medical view which is positivist and seeks to assess the universal cause of mental illness across different groups (Sampson, 1993; Gergen, 1994; McName & Gergen, 1992). Positivism focuses on seeking universal truth through the use of the scientific method, which is admirable but impractical (Sampson, 1993). This focus on positivism and pursuit of universal truth has resulted in many diagnoses being culturally bound, due to the different philosophies about self and reality (Aderibigbe & Pandurangi, 1995). Social constructionism moves the focus away from there being an internal deficit within the individual and refocuses on the external world (McNamee & Gergen, 1992). Sampson (1993) would argue that mental illnesses are social constructs that have formed through cultural and historical conversations between groups of individuals and not solely from a deficit within the individual.

In contrast, the scientific method seeks to explain psychological phenomena by examination, reducing things to their constituent parts, discovering and labelling them (Walker, 2006). This is the polar opposite to social constructionism, which suggests humans create

realities through the use of discourse. In the pursuit of scientific gratification, psychology has become guilty of linguistically warping, convoluting and confusing lived experience with essential "truths" (Walker, 2006). In terms of mental illness, psychology employs the scientific method which uses medical discourses that designate disease and deficit categories suggesting humans are like machines and can be "assessed", "diagnosed" and "treated" (Walker, 2006). These categories define what constitutes as "normal" or "abnormal", "acceptable" or "unacceptable" and thus compliance (Friedson, 1970; Foucault, 1977). Individuals being diagnosed as "abnormal" end up being burdened with the cultural connotations of their illness, as they endow meaning and erode their identity to create one that fits with their cultural view of said illness (Barker, 2005; Brown, 2007; Kroll-Smith & Floyd, 1997). Positivism infers that diseases occur freestanding of the etymology in which they are described and thus they are an "objective truth" and not a product of medical discourses creating the reality of illness (Turner, 1995). In light of this, Conrad and Barker (2010) emphasised the need for an eschewal of the strictly positivist notion of illness as the meagre personification of disease and a refocus on the social construction of illness.

Psychological terminologies used in diagnosis are not representative of reality, instead they make distinctions of a "reality", which as a consequence of the prevalent scientific method appear as "truth" and therefore paradoxically affect the actions of those being diagnosed (Walker, 2006). By illustration reified categories of mental illness are abstractions that are defined by clusters of symptoms (Walker, 2006). Individuals who have these symptoms are labelled as having a mental illness, for example schizophrenia. Thus these individuals are non-compliant with societal norms, however mental illnesses only exist through societal unanimity and persist through agreement (Walker, 2006). By using principles of the scientific method, mental health professions have monopolized the truth which has led to iatrogenic problems (Foucault, 1975). As a consequence, mental health professions have created a massive power imbalance through the use of medical language, which has led to humans being transformed into the mentally ill (Foucault, 1975). Viewing psychological diagnosis in a positivistic sense as an "objective truth" instead of as a socially constructed perspective has overwhelmingly destructive cultural and ethical consequences (Walker, 2006). For example, when the western mono-culture of what constitutes as a mental illness, is applied to non-western societies (Bhugra & Bhui, 2001).

There have been endeavours by psychologists to homogenize language classification and diagnostic systems across cultures, making the diagnostic criteria universal (Marsella & Yamada, 2010). However, this ethnocentric bias has led to frequent misdiagnosis and ethical harms as it is often taken for granted how certain illnesses are culturally taboo and have particular social and cultural stigmas, by illustration being diagnosed with a mental illness in some African cultures is believed to be caused by divine wrath, drug abuse and witchcraft (Conrad & Barker, 2010; Hassim & Wagner, 2013; Li, Hatzidimitriadou & Psoninos, 2014; Amuyunzu-Nyamongo, 2013). The western classification and diagnostic system should be viewed as a social construction because world views are not universal (Marsella & Yamada, 2010). A common misconception is to mistake the political power and economic dominance of western psychological assumptions, for accuracy which had led to a kind of pseudo global homogeneity in psychology and a veracity of cultural experience (Marsella & Yamada, 2010; Hassim & Wager, 2013).

The current model of the classification of illness used in psychology, takes the view that diagnoses and experiences are constant within culture (World Health Organization [WHO], 1992). However, social constructs within a cultural shape an individuals' views and experiences, which in turn influence behaviours (Hassim & Wagner, 2013) Culture shapes responses to illness and what constitutes illness (Prior, Chun & Huat, 2000; Helman, 1990; Olafsidottir & Pescosoldio, 2011). Therefore, a person of different culture may articulate similar behavioural tendencies, but express them according to culturally sanctioned norms, regardless of the aetiology of the illness (Hassim & Wagner, 2013; Tseng, 2006).

In the context of schizophrenia, the initial study by the WHO demonstrated the cultural contrast between how diseases manifested themselves, even after psychologists agreed upon the criteria for being diagnosed as schizophrenic (Sartorius, Shapiro & Jablensky, 1974). The differences in clinical outcome were remarkable, considering each patient was diagnosed as having schizophrenia (Eisenberg, 1988). Patients in developing countries at the time (Colombia, India and Nigeria), displayed noticeably less extreme symptoms, than patients from developed countries (UK, Russia and Denmark; WHO, 1979). Which was surprising considering the availability of "modern" treatment in the latter, this suggests that societal beliefs surrounding an illness can have real world consequences for the patients, psychologists and mental health professionals.

This dissimilarity was attributed to how cultural beliefs can affect cause and course of mental illness and how society responds to it; developed countries viewed it as a persistent biological impairment where an individual is in "remission" (Waxier, 1979). Whereas developing countries viewed schizophrenia as a curable condition, external to the individual (Waxier, 1979; Eisenberg, 1988). For example, schizophrenia can be explained by spirit possession which is not intrinsic to the individual and can exorcized returning the individual to their anterior self (Eisenberg, 1988). This contrasts the positivistic western view that schizophrenia is a chronic condition that is caused by something internal wrong with the individuals' brain (Eisenberg, 1988).

Various cultures have divergent social constructs on the reasons why individuals have mental illnesses. By illustration the Chinese believe that schizophrenia is a mind-split disease caused by taking things too hard or excessively thinking (Yang et al., 2010). Due to an inability to open up their mind to relief clogged feelings (Yang et al., 2010). The role of customary Chinese Confucianism is pivotal in shaping opinions and ideas of mental illness (Li et al., 2014). Chinese culture suggests that individuals diagnosed with schizophrenia lack control of their feelings and are unpredictable as they have deeply disturbed the code of harmony and balance, which has led to a loss in equilibrium (Yang, 2007; Zhang, 2007, Yang & Klienman, 2008; Yang et al., 2010). Furthermore, Confucianism emphasizes intrinsic worth of self-control and the capacity to withstand environmental stressors; therefore, people diagnosed with schizophrenia are seen as unable to endure, as opposed to the western view that there is a defect within their brain (Ikels, 1998). This view that mental illness is caused by an inability to endure, leads to individuals being regarded as "morally defective" as they lack the constitution to cope with their illness (Goffman, 1968). Individuals diagnosed with schizophrenia in China, are essentially shunned within their social circles (Yang, 2007).

In light of this for optimal diagnosis, symptoms should be construed within their cultural context and symbolic meaning attached to these symptoms as well as the sociocultural context that influences the visibility of said mental illnesses (Eshun & Gurung, 2009; Chandler, 1998; Connor-Greene, 2006; Hassim & Wager, 2013). Cultural influences suggest that opinions of normality and abnormality are regulated by culture, as they deem what is and what is not acceptable (Summerfield, 2001; Hassim & Wagner, 2013). Consequently, it should be the role of the clinician to take into consideration cultural norms and culturally specific expressions, when

making a diagnosis to prevent misdiagnosis of a mental disorder or a diagnosis that would lead to more harm (Connor-Greene, 2006).

Positivists' would make the argument that schizophrenia is a chemical imbalance of neurotransmitters within the brain, which they considered adequate proof of the disease model and that schizophrenia is a universal disorder (Marsellla & Yamada, 2010; Walker, 2006). The notion of a chemical imbalance has been applied to most mental illnesses because it gives credence to the theory that mental illness has a biological and therefore scientific basis, similar to physical disease (Walker, 2006). Connor-Greene (2006) argues that treatment of mental illness is characteristic of the prevailing paradigm at the time, for example The Infection theory of schizophrenia hypothesized by Dr Henry Cotton was popular in a time when bacteriological theories of disease gained scientific popularity (Scull, 1987). Cotton was convinced that schizophrenia was caused by an infection within the body, so he would remove parts of various internal organs to in order to produce a cure for schizophrenia (Connor-Greene, 2006).

The example of Henry Cotton is used as an anecdote to show how treatments and views on the cause of mental illness are historically and culturally bound. The current western view on the cause of schizophrenia is that biological changes in the brain lead to changes in the mind and therefore behaviour (Walker, 2006). However, current research suggests that mind and behaviour influence brain chemistry. In the context of schizophrenia, it is conceivable that physiological changes in the brain related to schizophrenia, are a result of the condition and the not the cause (Harrop, Trower & Mitchell, 1996). Mental illness should be viewed as reciprocal and iterative relationship, as opposed to a simple cause and effect (Walker, 2006). It is not inconceivable to suggest that psychological behaviours affect brain chemistry (Harrop et al., 1996). By illustration, medications change brain chemistry within specific regions of the brain, which in turn changes behaviour (Walker, 2006). In contrast, psychotherapies such as Cognitive behavioural therapy (CBT) or mindfulness training, work on the basis that better thinking changes brain chemistry, these therapies show the same effect on PET scans that powerful psychotropic medications do (Schwartz, 2002). Therefore, highlighting how a change in the mind can lead to a change in brain chemistry.

Applying the idea of a reciprocal and iterative relationship to the brain demonstrates how social constructs affect us biologically; the human brain intrinsically and automatically endeavours us to define, comprehend, forecast and regulate the world about us through the

organization of stimuli into complex principles and significance systems that convey our perceptions into regulatory behaviours (Marsella & Yamada, 2010). This process occurs through cultural socialisation, which creates templates that allow use to negotiate reality (Marsella & Yamada, 2010). Undeniably, mental illness has strong biological components, however localizing psychopathology in the brain, ignores how the context in which we live moulds our brains at the synaptic level, it is undeniable that events such as social change, violence and war leave an imprint on the brain or that numerous life stresses have no impact (Marsella & Yamada, 2010; Heinrichs,1993).

A critical review of the literature surrounding the idea that mental illness is socially constructed, highlights how the current diagnostic model is too positivistic. A narrow minded focus on the principles of the scientific method suggest that individuals are passive bystanders and that there is something pathologically wrong with them if they have a mental illness. The current diagnostic model fails to recognise that individuals are active participants within their culture, which has its own historical and conceptual views about mental illness. Therefore, being labelled as "mentally ill" although intended to help an individual, may have dramatic ramifications to an individual's ability participate within their culture. Aforementioned, research illustrates how social constructions effect brain chemistry, and how culture effects how behaviours associated mental illness manifest. Undeniably, mental illnesses have a biological component to them, however ignoring the effect of social and cultural constructions, ignores key components in an individuals' diagnostic journey. Therefore, moving forward clinicians should include a social constructionist view point into their diagnosis, as to ensure that they are not diagnosing someone as mentally ill for displaying culturally accepted behaviour.

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